NHS
Surrey Downs
Clinical Commissioning Group

Meeting Minutes

Governing Body

25th September 2015

Governing Body members present:

Dr Claire Fuller, Clinical Chair
Matthew Knight, Chief Finance Officer
James Blythe, Director of Commissioning and Strategy
Karen Parsons, Chief Operating Officer
Dr Simon Williams, GP, Epsom Locality Chair
Dr Robin Gupta, GP, Dorking Locality Chair
Dr Jill Evans, GP, East Elmbridge Locality Chair
Dr Kate Laws, GP
Dr Suzanne Moor, GP
Dr Russell Hills, GP
Dr Louise Keene, GP
Dr Ibrahim Wali, GP
Dr Andrew Sharpe, GP
Dr Mark Hamilton, Secondary Care Consultant
Peter Collis, Lay Member for Governance
Jonathan Perkins, Lay Member for Governance
Jacky Oliver, Lay Member for Patient and Public Engagement
Eileen Clark, Head of Quality

Others in attendance:

Justin Dix, Governing Body Secretary
Suzi Shettle, Head of Communications
Mable Wu, Head of Performance

Chair: Dr Claire Fuller, Clinical Chair

Minute taker: Justin Dix, Governing Body Secretary

Meeting started: 1.00 pm

Meeting finished: 3.50 pm

1. Welcome and introductions

Dr Fuller welcomed everyone to the meeting and those present introduced themselves. She particularly welcomed new lay member Jonathan Perkins and Dr Ruth Hutchinson from Surrey County Council's Public Health team. GB250915/001

2. Apologies for absence

Apologies had been received from Miles Freeman, Dr Hazim Taki, Gill Edelman, and Yvonne Rees. The Governing Body's independent observer, Cliff Bush, had also sent his apologies. GB250915/002

3. Conflicts of interests

The register of members' interests was noted as an accurate record. GB250915/003

Jonathan Perkins asked the Governing Body to note that he was a trustee of Princess Alice Hospice which related to the End Of Life Care strategy item on the agenda. There were no other issues noted relating to member's interests. GB250915/004

4. Minutes of the last meeting (for accuracy)

Eileen Clark raised two minor matters of accuracy which would be corrected with Justin Dix outside the meeting. GB250915/005

In all other respect the minutes were AGREED as an accurate record. GB250915/006

5. Matters arising and action logs

Eileen Clark updated on Never Events and directed members to the Quality and Performance report for further information. She gave an assurance that these would be routinely reported going forward. GB250915/007

Eileen Clark also updated on sepsis which it was acknowledged was a serious issue and would be more intensively reported in future. GB250915/008

The updates from Diane Woods at North East Hants and Farnham would be checked by Eileen Clark and come back to the next meeting. GB250915/009

6. Questions from the Public

Dr Fuller invited questions from members of the public present. GB250915/010

A member of the public asked about the financial structure of the CCG and how it would use its additional investment in the light of financial recovery. He would like to know how the money saved would be accounted for. GB250915/011

Matthew Knight said that there was some non-recurrent investment being put in place with the aim of investing to save. The programmes for investment and saving were bought together and reviewed with NHS England to provide assurance that everything was fully funded and that investments and savings were fully accounted for. GB250915/012

Mr Clifford said he was concerned about this and queried where the money would be disinvested from. He was specifically concerned about reductions in the funding of community hospitals and patient transport and the potential impact on acute services. GB250915/013

James Blythe acknowledged these concerns. The relationship between community and acute was a feature of the Community Hospital review and detailed financial modelling was being undertaken as part of the work but he said the aim was not to impact on acute services. GB250915/014

A written question had been submitted by Rosemary Najim regarding anti-coagulation, as follows: GB250915/015

"Are the GP members of the Board, other than Claire Fuller who has been involved with talks on this, aware that the Cardiac re-design pathway organisers have agreed to have cardiac hubs but, in the same way that last year's re-design plan failed, have not agreed to include commencement of anti-coagulation of new AF patients seen at the hubs. If this is not agreed at the meetings the CCG have organised in October, it will mean the 54% of AF patients with a relevant Chads Vasc2 score who are not presently anti-coagulated will continue to be at high risk of stroke. I have asked for AF patients to be swiftly anti-coagulated for the past two years and we still have patients attending our AF support group who have not been anti-coagulated until they have had TIAs or strokes. If no agreement is reached I do intend to start a public campaign about this but would ask all GPs on the board to help to press for this so that campaigns are not needed." GB250915/016

Dr Williams commented on behalf of the CCG and said that Mrs Najim's concerns were acknowledged. Timely intervention was important and he described the development of provider hubs to support diagnosis and treatment in a series of phases of work. There were also initiatives to audit GP records to see how appropriate existing diagnosis and use of anti-coagulants was in practice. GB250915/017

There was some discussion about appropriate treatment as not all treatments were suitable for all patients. Dr Wali said that a discussion with each patient was necessary to manage clinical risk and determine the most appropriate treatment. GB250915/018

7. Update on Directions from NHS England

Dr Fuller asked the Governing Body to formally note that the CCG had been placed under Direction from NHS England and outlined the nature of the Directions which principally concerned leadership and governance. GB250915/019

The CCG had met with regional and sub-regional representatives this week to review these issues and the Financial Recovery Plan which was a central part of the directions. They had also visited Epsom as part of this visit. GB250915/020

8. Chief Officer's Report

A number of specific issues were highlighted from the report. GB250915/021

Dr Fuller noted that CCG commissioning intentions and other organisations' plans had been reviewed at the last meeting and it was re-assuring how much convergence there was in each partner organisation's approaches. However the analysis of Surrey Police data showed a worrying incidence of calls regarding the NHS, particularly safeguarding issues. GB250915/022

Dr Hamilton asked about the Referral Support Service under the transformation heading and the percentage of referrals going through this service. James Blythe said that currently the figure was around 70% and further development was taking place to achieve a practical level of around 95%, given that there would always be some appropriate exceptions. GB250915/023

Dr Evans noted the work on crisis care in mental health and the potential to provide a more co-ordinated response between agencies. GB250915/024

Peter Collis asked about the financial controls assessment and when this would be circulated to members. Matthew Knight noted that the rescheduling of meetings had made this difficult but it was going to the audit committee on the 14th October. Peter Collis and Matthew Knight would discuss the subsequent handling of this outside the meeting. GB250915/025

Action Peter Collis / Matthew Knight

9. Surrey Downs Public Health Profile

Ruth Hutchinson introduced this. It was a 120 page document of which her presentation was just a very brief summary. It was Surrey Downs CCG specific and she would provide members with a link to the more detailed information available on the internet on the public health web site. GB250915/026

Key issues were as follows: GB250915/027

SDCCG had an ageing population with inward migration

- There was a complex ethnic population mix although a majority of the population were white British
- Life expectancy was generally good but there were some significant variations with life expectancy ranging from 75 to 86 depending on which ward you lived in.
- The CCG was third in the UK for "healthy life expectancy"; however within this there were again some significant variations.

- An analysis of potential life years lost showed the geographical areas and health conditions the CCG needed to target. There was good data on health inequalities, and on specific indicators such as fuel poverty.
- The CCG could improve its winter vaccination figures and there would be a strong push on this commencing shortly. Childhood immunisations had improved but were still below desired “herd immunity” levels.
- Alcohol abuse was above national levels and impacted in other areas e.g. domestic violence and hospital admissions in some cases. Smoking prevalence was however improving with some hotspots in specific areas.

Ruth then explored some specific issues in detail such as hypertension, diabetes, stroke and coronary heart disease which illustrated the above themes. GB250915/028

Dr Fuller thanked Ruth Hutchinson for her presentation and noted that there was a wealth of interesting and important data within the report that the CCG could draw on in its commissioning work. GB250915/029

Dr Hills noted the issues with flu vaccine and the need to counteract negative media messages. Ruth said that there was clearer information coming from Public Health England on this to support local initiatives. Karen Parsons noted that practice managers were also concerned about communication in this area. GB250915/030

Dr Moore noted the good work on vaccination in NW Surrey CCG that the CCG could learn from. GB250915/031

Jonathan Perkins asked if particular wards were targeted around health inequalities. Karen Parsons said that there was a Public Health prevention strategy which was renewed annually and had identified local outcomes. GB250915/032

James Blythe noted the workforce issues which would probably get worse and impact on the NHS’s ability to deliver services. This would be a key issue in addressing the above variations. GB250915/033

Peter Collis felt that even ward level data did not tell the full story and that some issues were very local. Dr Sharpe said that practice level data would be useful in this context and Ruth said that some data could be extrapolated but did tend to be weaker at this level. GB250915/034

Dr Fuller summarised the issues from the discussion and said that workforce did keep coming up as a major constraint and an area of concern. GB250915/035

10. Five year forward view

James Blythe summarised this and how the local strategies aligned with it. Integrated working between health organisations and between health and social care was a key theme, with different approaches in each locality to reflect local variation. GB250915/036

These approaches were similar to the Vanguard bid that the CCG had prepared in February 2015 and a similar project was being developed around the Epsom health economy.

GB250915/037

There was a general consensus around the need for integration of acute and community services, with ongoing service transformation to support this, for instance community medical teams. Discussion was continuing between the organisations responsible for different areas of service delivery about how best to match local aspirations to the vision in the five year forward view. This also needed to fit with the Financial Recovery Plan and the need for a concerted health economy wide approach. But in overall terms the Governing Body could be assured that the national and local strategies were in agreement even though more work was needed on funding flows and service changes.

GB250915/038

Dr Hamilton asked if this was genuinely achievable at national level given the £20bn gap in funding, and James Blythe acknowledged that this had been worked through locally and the figures were very challenging at every level. However there was a lot of scope for efficiency although it was not clear at this stage whether traditional efficiency gains alone would be sufficient. Matthew Knight noted that the operating models at local level were not proscriptive and adapting them to local approaches would be necessary.

GB250915/039

Peter Collis noted that the CCG's different strategies were convergent but not necessarily integrated at this stage. Bringing them into line would be part of the challenge for this year's planning round. James Blythe agreed and said the CCG needed to articulate an integrated and coherent view. Matthew Knight noted the CCG also had to take the public sector spending review into account and the NHS wide implications of this.

11. Community Hospitals' Consultation

GB250915/040

Dr Fuller thanked James Blythe and the other staff and clinical leads involved in this programme for a very thorough and transparent approach. She asked James Blythe to summarise what the Governing Body was being expected to approve.

GB250915/041

James Blythe noted this was an important stage in the journey towards ensuring that Community hospitals best served local patients' needs. There had been some difficult operational issues arising from this review, and it was clear that there was a need for evolution in the local approach. The process had been extensive and had resulted in a proposed road map for clinically sustainable services. The report's recommendations were based on giving some certainty about the future.

GB250915/042

James Blythe particularly thanked Tom Elrick, Jade Winnett and Suzi Shettle for their very positive work on engaging with the public and stakeholders, and CSH Surrey for their direct and practical support. There was more to do and SCC had offered to support the consultation process.

Local people would continue to be involved in the work and the consultation process, with a decision in the new year. He asked the GB to agree to go out to public consultation on the proposals set out in the paper, noting the four options. The community estate also needed to be considered. GB250915/043

Jacky Oliver confirmed that the engagement processes had been very good and commended the work done to date. GB250915/044

Jonathan Perkins asked how the four options fitted together as it was unclear how each area was affected under each one, particularly Dorking. James Blythe said that under every option Dorking would not be affected. GB250915/045

Dr Gupta queried the statistics on pages 50 and 51 (Table 22) and these were clarified as correct by James Blythe. GB250915/046

The Governing Body AGREED to go to consultation as set out in the paper. GB250915/047

12. Stroke

Dr Fuller spoke to this and the need for change, particularly preventing premature death and disability arising from stroke. GB250915/048

James Blythe set out the work of the Stroke Change Project and the need to do this on a county wide basis. Services could not be provided at CCG scale because of the clinical workforce requirements of effective services, and a different service model operating across a wider geography would be necessary. GB250915/049

The Committee in Common approach was designed to support the necessary decision making. Public engagement was supporting this and it would be necessary to articulate the case for change and consult on it before any changes were made. GB250915/050

The membership of the committee for Surrey Downs would be Dr Fuller and Jonathan Perkins with James Blythe as an observer, which was consistent with other CCG's approaches. GB250915/051

Dr Fuller reiterated that this was a consensus based approach between the CCGs but the Governing Body was giving its representatives delegated authority to make decisions on its behalf. GB250915/052

Dr Hills asked about timescales and it was clarified that implementation would be from 2017 onwards. GB250915/053

Dr Moore noted that there was a similar approach for CAMHS and asked how she, as a delegated individual, could exercise the Governing Body's wishes. Dr Fuller outlined the process and the need for members to have adequate time to consider all the issues. GB250915/054

The terms of reference and delegation arrangements for the Stroke Committee in Common were AGREED. GB250915/055

13. End of Life Care

Dr Laws introduced this and outlined her professional experience of providing a good experience to families when someone was dying. She had been involved in work over the last year on this with providers of care. GB250915/056

The Governing Body then watched a video entitled “I didn’t want that” produced by the Dying Matters coalition. GB250915/057

Dr Laws set out the aims and objectives of the End of Life Care Steering Group as follows: GB250915/058

- Ensuring a higher number of patients achieve their preferred place of death
- Increase the levels of community engagement and education to ensure everyone knows of the services available to support the dying patients
- Workforce training and education that is offered across the whole system
- Identification of frailty in order to avoid crisis and ensure pro-active management, and improve recognition of the ceiling of care for an individual both in hospital and the community (recognising when someone is dying)
- Encourage active use of advance care planning

Residents of SDCCG were not dying in their preferred setting and too many were dying in hospital; in fact the CCG was one of the poorest nationally. There were a number of service areas for improvement. These included: GB250915/059

- Palliative Care
- Shared Care Plans (supported by workable IT solutions)
- Workforce training (targeted on GPs and care homes)
- Patient Education
- Bereavement Services (particularly improving the knowledge of GPs)
- Telephone triage and support

It was acknowledged that existing capacity in hospices was insufficient as was home support and this would be a challenge to address. GB250915/060

A range of proposed changes were set out in the document. These would improve the experience of patients and families. Timelines set out in the document would need to be updated. GB250915/061

Dr Evans said that she fully supported this approach and recent experience in her locality supported the need for planning for the future for individual patients. Community hubs needed to be fully supportive of this. Dr Gupta agreed and said there was currently a big variation between GP practices even within localities. GB250915/062

Dr Hamilton commended the strategy and asked what level of service would be needed in future. Dr Laws said that the majority of people would want to die at home but the hospice sector also needed to expand. Jonathan Perkins said that a lot of hospice work was community based and not bed based, and hospices had in fact reduced the number of beds as they were not equipped to deal with very complex end stage patients. Dr Hamilton said that hospitals had to help with this; sometimes even helping people to go home just for the last day or two of their lives. GB250915/063

Eileen Clark also commended the proposals but cautioned that workforce issues were the biggest single risk to achieving it. One issue currently was difficulty with work permits for overseas nurses. GB250915/064

Peter Collis asked about the comparative costs of hospital and home care for dying people. Dr Laws said that advanced care planning could avoid unnecessary hospital admissions and in her view dying at home was cost neutral given the level of under-utilised community resource locally. GB250915/065

Karen Parsons emphasised that this all fitted with the integration agenda, and the need for closer joint working that targeted specific sectors such as care homes. GB250915/066

Dr Wali emphasised the need for good information systems and information sharing, bringing together 111, hospices, out of hours and other aspects of care pathways. There was key information that all agencies needed and so far the existing IT solution for a shared care record had not delivered this. GB250915/067

Jonathan Perkins emphasised the holistic approach – the patient, the carer and the family. There was also a need to support the staff who were often under stress from their work, and recommended counselling opportunities for them. Research showed this gave better professional outcomes. Jacky Oliver agreed with holistic care approaches and said the CCG should keep this in mind at all times when supporting families. GB250915/068

The Governing Body AGREED the strategy and the support of community hubs in delivering it. GB250915/069

14. Commissioning Intentions

James Blythe spoke to this item and explained the timescales involved in agreeing the services that would be commissioned from next April. There would be a dialogue with providers as part of this process as well as wider engagement with member practices. It was important that this was integrated with the Financial Recovery Plan and timescales for investment. There was an expectation that all initiatives made a contribution to the Financial Recovery Plan whilst maintaining quality and performance. GB250915/070

Localities would be consulted during October and there would be discussions at the Council of Members level as well, prior to further discussion at the next Governing Body. Providers would be given clear messages about potential service changes. Some of these would relate to planned or proposed changes across more than one CCG in some cases. GB250915/071

Dr Moore reiterated the importance of the patient and public voice in the process. Suzi Shettle said that there were a number of ways this was being done including an online survey which so far had yielded a hundred responses. Dr Wali suggested this should encourage patients to feed back via practices. GB250915/072

15. Quality and Performance Report

Eileen Clark spoke to this. A number of specific risks were highlighted as follows. GB250915/073

Cancer 62 day waits – Epsom St Helier performance was poor and the CCG was working closely with the provider following a visit from the national support team. A trajectory for improvement was being closely monitored. GB250915/074

CDiff incidence – community acquired infections were increasing and this was down to a variety of factors including antibiotic use, patient frailty, and increased testing. Work was being done to understand the root causes of each case but trend identification was proving difficult. GB250915/075

Children's services were a concern, particularly in relation to incoming refugees and the implications for child safeguarding. The risk was that the NHS would not be able to meet its statutory duties in this area. GB250915/076

Dr Sharpe asked about CDiff and what the natural rates of infection were that were not associated with antibiotics. Eileen Clark said this was a complex area and there was little evidence in most cases of inappropriate antibiotic use. Dr Fuller and Dr Wali highlighted the complex statistical variations that were available from published national statistics. GB250915/077

James Blythe added on cancer waits that Epsom St Helier had done a lot of work that they had presented to the CCG and NHS England and there were two very specific pathways involved. Two Week Referral volumes and issues with pathway management were significant factors. There needed to be more work done on whether active treatment was the right approach in every case. Dr WIlliams noted the new NICE guidance on cancer which might be part of the context of this. GB250915/078

Dr Hills noted that Surrey and Sussex Trust performance had improved in the report and Eileen Clark said the trust should be given positive feedback on this. GB250915/079

Dr Fuller asked about Two Week Rule referrals for breast cancer "not suspected" on P11 of the report. Mable Wu agreed to circulate the definitions behind this, which related to the Marsden. GB250915/080

Action Mable Wu

It was noted that the trust were themselves concerned about this and wanted to discuss this with GPs at the next GP update meeting. GB250915/081

Dr Gupta noted an error on P29 relating to Never Events. This would be corrected. GB250915/082

16. Finance Report

Matthew Knight spoke to this. The CCG's current spend was in line with plan, with some areas of overspend (in acute services) which were offset in other areas, mainly non-acute orthopaedics. This would still leave the CCG with a cumulative deficit of £28m by the end of the year. GB250915/083

QIPP savings had been reduced by £3.7m but these were offset by non-recurrent benefits and a phased approached to QIPP savings in other areas. Overall elective spend was on track. GB250915/084

There were risks around increasing activity over the winter months and potential failure to achieve contract challenges. There were also risks around QIPP. Potential mitigation included further prescribing savings. GB250915/085

The focus now was on 2016/17 planning and ensuring that the commissioning intentions delivered the required savings in that year. GB250915/086

Peter Collis noted that the figures had been shared with NHSE and asked if the deficit was funded by release of cash from the centre. Matthew Knight confirmed it was but the rules were complex. GB250915/087

Peter Collis then asked about data quality and practice level discussions, and Dr Fuller confirmed that practices were receiving packs that benchmarked them against other practices and these were being followed up with specific conversations. One emerging theme was that private referrals had reduced dramatically which was having an impact. GB250915/088

Dr Moore asked about changing patterns of elective referral. James Blythe said that the over-performance was in specific areas such as endoscopy and ophthalmology, and outlined the underlying issues for these. Wet AMD was a particularly expensive pathway because of the number of appointments and the cost of treatments, which did not exist as a pathway a few years ago. GB250915/089

Dr Fuller highlighted the need to reduce growth rates in activity from 5% to 2% in order to achieve the Financial Recovery Plan. GB250915/090

Dr Hamilton said that the change in private referral patterns and what appeared to be a shift from private to NHS care was very striking and it was noted that NHS England was very focused on this. GB250915/091

17. Risk Register and Assurance Framework

Matthew Knight introduced this. It was acknowledged from recent external reviews that risk needed to be more central to the CCG's management approach and culture in future. There would be a greater alignment between risk and the organisation's objectives and risks, and a new risk management system was being implemented. GB250915/092

Matthew Knight highlighted the risks associated with the Financial Recovery Plan and specific programmes and the role of the Finance and Performance Committee in monitoring this. GB250915/093

Acute contracts were an inherent risk. Stroke reflected the discussion that had taken place earlier. The workforce issues associated with community hospitals had also been discussed. GB250915/094

The quality premium risk was specifically noted. GB250915/095

Given the scale of change, the risks around the constitution being out of date were specifically noted. GB250915/096

Peter Collis asked about talent management as he felt this was a general risk in the NHS but a specific risk to Surrey Downs CCG. Matthew Knight agreed; this could be managed through contractors but this was an expensive solution. The Remuneration and Nominations Committee would be focusing on this issue going forward. GB250915/097

18. Audit Committee Report

Peter Collis said there was no additional update to that given in the minutes. GB250915/098

The Audit Committee Report was NOTED. GB250915/099

19. Finance and Performance Committee Report

It was noted that the meeting going forward would be chaired by Jonathan Perkins. GB250915/100

The Finance and Performance Committee report was NOTED. GB250915/101

20. Quality Committee Report

Dr Moore highlighted the Ofsted report and how this had identified referral problems with social workers. There were risks around sexual exploitation and a need for better data and education. GB250915/102

21. Remuneration and Nominations Committee Report

Jonathan Perkins highlighted the discussion on Organisational Development and the significant amount of work that would need to take place between now and the end of the financial year. GB250915/103

22. Primary Care Committee Report

The Primary Care Committee Report was NOTED. GB250915/104

23. Any other business

There was no other business. GB250915/105